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João Leal, Carla Cunha, Anita Santos & João Salgado

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ORIGINAL PAPER

Helping Clients Victimized by Intimate Partners Through Stages of Change: An Emotion-Focused Approach

João Leal[1,2] · Carla Cunha[1,2] · Anita Santos[1,2] · João Salgado[1,2]

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Abstract
Intimate partner violence results in extensive negative mental health outcomes including depression, posttraumatic stress, and anxiety. Moreover, victimized partners who experience cumulative episodes of abuse over time can also present severe affect dysregulation and interpersonal difficulties. Preliminary evidence for existing psychological treatments shows that these are globally effective on a symptomatic level and in reducing revictimization. Nonetheless, systematic reviews show high attrition rates and suggest that future interventions need to address a wider range of emotional difficulties and contextual challenges according to readiness for change. In this article, our goal is to contribute to the development of more responsive interventions that are tailored to individual experiences of violence with a focus on personal values, self-determination, and autonomy, as well as promoting adaptive coping and safety. More specifically, we describe how the intervention principles and experiential tasks of a neohumanistic model, emotion-focused therapy, can be integrated into a mediating readiness for change framework to help victimized clients receiving psychological treatment. We address four main problematic content-affective states that may hinder the therapeutic progress (interrupting fear of change, decisional pain, overwhelming safety concerns, and long-term interpersonal injuries), their association with stages of change, and how they can be resolved in-session using emotion-focused principles and interventions. The implications for future research are also discussed.

Keywords Intimate partner violence · Emotion-focused therapy · Stages of change model · Psychotherapy · Victimization

Introduction

This paper describes how intervention principles and experiential tasks from emotion-focused therapy (Goldman & Greenberg 2015; Greenberg 2015) can be integrated in a tailored stages of change model (Prochaska & Norcross 2014; Reisenhofer & Taft 2013) to help clients victimized by intimate partners receiving psychotherapy. Our goal is to contribute to the development of psychological interventions that are more flexible in addressing personal experiences of violence, respect the client's autonomy and self-determination, promote safety, and support adaptive coping by facilitating access to internal and external resources (Sorrentino et al. 2020).

Intimate partner violence is the most commonly committed crime against women, and it refers to the self-reported experience of violent acts perpetrated by a partner within the context of a current or previous intimate partnership (World Health Organization 2013). It is estimated that 30% of women worldwide have already experienced physical and/or sexual abuse perpetrated by their partners (Devries et al. 2013) and that 38.6% of female homicides are committed in the context of a former or current relationship (Stöckl et al. 2013). Intimate partner victimization is also significantly associated with symptoms of depression, post-traumatic stress disorder (PTSD), anxiety, and drug abuse (Lagdon et al. 2014).

Victimized partners who experience coercive patterns of physical and/or sexual abuse and control tactics over time

✉ João Salgado
jsalgado@ismai.pt

João Leal
d011792@ismai.pt

Carla Cunha
ccunha@ismai.pt

Anita Santos
anitasantos@ismai.pt

[1] University Institute of Maia-ISMAI, Av. Carlos Oliveira Campos-Castelo da Maia, Avioso S. Pedro, 4475-690 Maia, Portugal

[2] Center of Psychology at University of Porto, Porto, Portugal

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(e.g., intimidation, threats, emotional and economic abuse) are more likely to report higher levels of clinical distress when compared to victims of situational violence (Tiwari et al. 2015). In these cases, women may present a more complex symptomology that is associated with experiences of cumulative and extreme abuse, including a sense of a "damaged self", severe affective dysregulation, and aggravated interpersonal difficulties (Bogat et al. 2013; Herman 1992).

Most existing psychological interventions for victimized clients are adapted cognitive-behavioral protocols focused on symptomatic reduction and the promotion of safety. These have shown promising preliminary results for reducing PTSD, depression, and revictimization rates (e.g., Johnson et al. 2016). However, research on clinical trials for this population shows that a significant number of non-completers may be not yet ready to engage in or completely benefit from treatment due to contextual challenges, longer history of violence, and higher levels of distress, thus suggesting the need for more tailored interventions (Evans et al. 2018; Trabold et al. 2018; Warshaw et al. 2013). For example, women who have endured cumulative and coercive patterns of abuse, in particular, could benefit the most from flexible interventions that also address aggravated emotional and relational difficulties, which are not usual targets of symptom-focused treatments (Bogat et al. 2013; Warshaw et al. 2013).

We would like to argue that experiential principles and interventions, when specifically tailored to address readiness for change, can yield additional treatment gains, especially considering that their main focus is on the moment-by-moment processes that underlie self and interpersonal difficulties and affect dysregulation (for a more in-depth discussion, see the study of Gleiser et al. 2008). Emotion-focused therapy, in particular, has received empirical support for the treatment of interpersonal trauma (Paivio et al. 2010) and depression (Goldman et al. 2006), and, as a potential transdiagnostic model, is particularly well-equipped to address the core emotional vulnerability that underlies symptomatic clusters (Timulak & Keogh 2020).

We will now review the research into applying on the stages of change model to the experiences of this client population, and we will describe how emotion-focused intervention principles and specific experiential tasks might be refined according to a readiness for change framework. We then conclude this study by briefly discussing the implications for future research.

A Readiness for Change Approach to Intimate Partner Victimization

The concept of readiness for change relates to the stages of change model that was initially proposed by Prochaska and DiClemente (1982). This model proposes that people change by progressing sequentially through five discrete stages to potentially resolve their behavioral problems. According this framework (Norcross et al. 2011), clients in *precontemplation* are usually unaware of their problems, or they do not explicitly acknowledge them. In the *contemplation* stage, meanwhile, clients recognize the problem and actively engage in considering ways to overcome it. In the *preparation* stage clients try small changes and aim to take significant action in the next month, while in the *action* stage, clients successfully modified behaviors, experiences, and/or environmental factors for a period ranging from a day to 6 months. In the *maintenance* stage, clients are focused on preventing relapse and consolidating their gains for more than 6 months.

It may seem that this model is generally adequate for describing the process of change for the victims of intimate violence. Nonetheless, several authors have noted that adhering to this standard criteria for classifying the change efforts made by this population may incur further invalidation of the victimized partner by service providers (e.g., Burke et al. 2009; Chang et al. 2006; Cluss et al. 2006).

First and foremost, intimate partner violence cannot in itself be understood as a "behavioral problem" on the part of the client alone, as would be more the case with addiction or other health habits. Indeed, victimized clients are not responsible for their partners' abusive acts, with them having agency only over their own processes, as well as having limited power to change their environment (Bliss et al. 2008; Burke et al. 2009). Secondly, the original stages of change framework does not fully account for the personal and external determinants that play a significant role in the common non-sequential movements towards change (Cluss et al. 2006). For example, victimized partners can often "leapfrog" from one initial stage to a much more advanced position (e.g., precontemplation to action) in reaction to external events (e.g., an episode of extreme violence) (Chang et al. 2006). Finally, women may simultaneously show indicators of more than one stage at any given time, suggesting that the change toward a violence-free life is better viewed as a continuum or even a multidimensional process rather than a progression through a discrete set of categories (Bliss et al. 2008; Cluss et al. 2006).

These limitations are addressed in Reisenhofer and Taft's (2013) critical review of studies that relied upon the stages of change model to analyze the experiences of victimized women. The authors conclude that health practitioners should, as a baseline goal, minimize harm and promote well-being across all stages of change, regardless of whether the victim decides to terminate the intimate relationship. Change, therefore, is reframed as a multidimensional continuum of (re)defining and achieving idiosyncratic goals of safety and well-being according to the prevailing difficulties. Thus, progress is conceptualized as a result of learning and

successfully implementing effective strategies to increase one's well-being and to keep oneself safe, all within a collaboratively defined overarching goal (i.e., staying safe in the relationship or staying safe during and after leaving it).

However, how can psychotherapists, in particular, best help a victimized client using a coherent rational and associated therapeutic techniques while assuming safety and the promotion of well-being as the global goal that needs then to be idiosyncratically framed?

Resolving Problematic Content-Affective States across Stages of Change

Emotion-focused therapy adopts a constructivist view of human functioning that assumes that emotions provide personally significant information about what is the most important path for achieving well-being, which in turn guides behavior and meaning-making processes (Greenberg 2011, 2015). Thus, emotion-focused therapists help clients by promoting specific affective processes—such as awareness, expression, regulation, reflection and transformation—in the context of a corrective therapeutic relationship (Greenberg 2011). Through these processes, therapists help their clients to overcome global feelings of distress (e.g., helplessness, hopelessness, hypervigilance) and problematic self-treatment (e.g., self-criticism, self-interruption) to access the core emotional pain associated with unmet needs (i.e., to feel connected, accepted, and safe), and to develop transforming self-compassion and/or protective responses, ultimately leading a client to enhanced relief, agency and empowerment (Timulak & Keogh 2020).

Rather than following a pre-determined, content-focused session structure, emotion-focused therapists embrace the process-directive principles of balancing between following the client's experiencing, and guiding the client through the resolution of a collaboratively identified affective difficulty (i.e., "marker") with a specific therapeutic task (Elliott et al. 2004; Goldman & Greenberg 2015). In this sense, emotion-focused therapy and the stages of change model share a common denominator. Both match interventions to the current idiosyncratic needs of the client. While the former perspective proposes that the therapeutic process should encompass "arriving" at a given emotional processing difficulty and then "leaving" this state through emotional change (Greenberg 2015), the latter suggests that clients progress towards change by engaging in specific stage-related tasks that match their level of readiness (Prochaska & Norcross 2014). Thus, we propose that therapists can help victimized clients by becoming aware of how a specific content-affective state may be preventing progression towards a change stage and then suggest a tailored task to resolve the underlying emotional difficulty.

We propose that four key problematic content-affective states are likely to occur in this population: (a) fear of change, (b) decisional pain, (c) overwhelming safety concerns, and (c) long-term interpersonal injuries. Resolution of these underlying emotional difficulties may be then facilitated by engaging in specific emotion-focused tasks. Two-chair enactment and dialogue are suggested to deal with fear of change and decisional pain, respectively. Fear of change is likely to present itself as a self-interruption split blocking progression from precontemplation to contemplation, and decisional pain relates to deeper self-shaming splits that are likely to occur in the transition from contemplation to action. Clearing a space is also suggested to help clients across all stages to resolve a sense of being overwhelmed with multiple safety concerns, but it is likely to be even more helpful for victimized clients already engaged in change efforts (i.e., preparation, action and maintenance). Lastly, once the necessary internal coping responses and external factors are stable (i.e., from maintenance to termination), imaginal confrontation is proposed to facilitate emotional transformation of the core pain associated with the emotional vulnerability of the victimized client.

It is, however, important to remember that these content-affective states are likely to be present differently across all the stages and associate with one another. We suggest that therapists and clients can collaboratively decide in-session, at a given time, which task to engage in when a specific difficulty seems to present the main obstacle.

Two-Chair Enactment for Interrupting Fear of Change

Victimized clients may be considered at the *precontemplation* stage if they report a sense of global distress, endorse traditional values about family and femininity, and hope for "magical change" (Zamora et al. 2012). Women victimized by controlling partners can also often attempt to justify the violence due to jealously and failure to meet oppressive gender expectations (Joshi et al. 2020). Intimate partner violence is therefore not completely denied, but clients may view themselves as the problem (Reisenhofer & Taft 2013). At this point, victimized clients may be coping with an internal conflict between a paralyzing fear and a core need for safety by engaging in avoidance strategies (e.g., "I tell myself that I'm not a battered woman") (Bauman et al. 2008). For this reason, victimized clients may seek therapy for other health-related concerns while interrupting themselves from disclosing the abuse or expressing it as a clear problem.

Therapists who are attentive to this emotional difficulty can tentatively offer to reflect on it with the client (e.g., "It seems as if there's a part of you that silences your struggle—does that make sense?") and propose *two-chair enactment* to

resolve self-interruption processes that hinder the access and expression of disowned experiences (see chapter 11, Elliott et al. 2004). This task can provide an opportunity to express, address, and reflect upon how oppressive internalized social narratives constrain the emotional processing of "shameful" emotions (Levitt et al. 2019). For example, expressing dissatisfaction toward a marital relationship may be severely frowned upon in the client's community, thus contributing to maintaining the split between a self who blocks adaptive anger toward abuse and the self who is experiencing oppression. By helping the victimized client to enact the interrupting aspect of the self and reflect upon the paralyzing effect it has on the experiencing self (using different chairs or imagination), therapists can promote a negotiation between these conflicting voices that will allow the expression and acceptance of anger toward violation (e.g., "I can't hold this inside anymore!"), which in turn encourages a resolution of this *precontemplation* challenge (Reisenhofer & Taft 2013; Shurman & Rodriguez 2006).

In summary, working on this problematic affective state at this stage with the *two-chair enactment* task can translate into a greater awareness, contextualization, and integration of disowned needs, as well as a change in the maladaptive coping processes that may hinder therapeutic progress (i.e., experiential avoidance). As the perception of their own internal resources for coping with painful feelings increases, and the therapeutic bond strengthens, victimized clients may gradually feel safer about discussing abuse and clearly address its problematic aspects with the therapist. Therefore, clients would progress from precontemplation once the self-interrupting split is resolved.

Two-Chair Dialogue for Decisional Pain

Victimized clients described as being at the *contemplation* stage are likely to be primarily struggling with their awareness of the abuse as something problematic and the need for change while holding onto traditional family values, positive emotions, and feelings of loyalty toward the partner (Eckstein 2011; Zamora et al., 2012). In such cases, confusion, guilt, and self-blame can arise in an attempt to attribute meaning to the abuse perpetrated against them (e.g., "This is only happening because I'm not a good wife") (Lim et al. 2015). Holding negative views of the self, such as shameful or guilty, may then contribute to problem-solving avoidance, thus inhibiting victimized clients from making significant changes (Tran et al. 2019). Therefore, while there is a clear recognition of the abuse and its negative consequences, and even if some small steps have been taken (i.e., *preparation*) (Reisenhofer & Taft 2013), victimized clients may still feel conflicted about developing and implementing a sustained action plan for fear of engaging in behavior that is stigmatized by the systems to which they belong (e.g., family, church, community, society) (Buchbinder & Karayanni 2015; McCleary-Sills et al. 2016).

From an emotion-focused perspective, painful self-evaluations can emerge from a conflict between the experiencing self that seeks change and a harsh, critical, internalized voice (e.g., "You can't do anything right." or "This is all your fault."), resulting in a tendency to avoid others and suppress individual needs (Elliott et al. 2004; Timulak & Keogh 2020). With victimized clients, this deeper self-critical split is likely to become more present in-session when a decision to engage in change is made, or when clients are no longer willing to work toward their safety and well-being (i.e., "collapsed self"). In these situations, clients may be struggling with a "self-shamer" aspect that inhibits protective feelings of being worthy and entitled, resulting in a painful "abuse-shamed" self that remains stuck and non-agentic towards the abuse.

Therapists may perceive these self-evaluation markers and propose a *two-chair dialogue* task to help victimized clients to identify the values and motivation of the "shamer", and to own the organismic response associated with the unmet needs of the experiencing "shamed" self (see chapter 11, Elliott et al. 2004). Therapists can then help the victimized client to take action by helping them "fight" their internal systematized critic based on the identified unmet needs (e.g., feeling worthy of safety and acceptance). This process is followed by negotiation between the two self-aspects, leading to a new meaning perspective that organizes protective and agentic action tendencies toward mitigating the abuse.

For example, hindering decisional conflicts can be resolved by experientially arriving at a shared agreement that it is never worth enduring abuse for the sake of maintaining a relationship. This work will require the negotiation between an aspect of the self who prioritizes maintaining a relationship and another aspect that experiences the cost of being abused in that relationship. Arriving at and owning a protective self-empowering value can then help clients to define tangible personal goals and engage in planning significant actions based on the current situation (e.g., leave the partner or mitigate the abuse in the relationship) (Chang et al. 2010; Reisenhofer & Taft 2013). At the same time, a gradual softening and integration of the internalized self-critical aspect can lead to changes in coping responses that would otherwise increase risk and distress (e.g., self-criticism, self-blame, and interpersonal avoidance; see also Rizo et al. 2017), thus strengthening new agentic ways of responding to interpersonal and contextual triggers (e.g., self-care, seeking helpful relationships).

Clearing a Space for Overwhelming Safety Concerns

Therapists may propose a tailored *clearing a space* task to help victimized clients cope with a sense of being attentionally flooded by urgent concerns across all stages of change because it provides the opportunity to create and maintain a productive working distance and a safe internal space (see chapter 9, Elliott et al. 2004). Research shows that even while facing the challenges of *precontemplation* and *contemplation*, victimized women experiencing ongoing abuse actively work toward their safety by either taking small steps (*preparation*) or engaging in significant efforts over time (*action*, *maintenance*) (Reisenhofer & Taft 2013; Zapor et al. 2018). As a result of these efforts, victimized partners may be confronted with unexpected costs for themselves and their children (e.g., the loss of financial stability or a lack of physical safety and social support) (Thomas 2015), intense fear of being revictimized (Ivany et al. 2018), and increased stress at taking on overwhelming responsibilities (e.g., housing, parenting, employment) with insufficient resources (Edhborg et al. 2015; Estefan et al. 2016). We also believe that this task could be particularly important for clients who are preparing to leave an abusive relationship (*preparation*), or have already left (*action/maintenance*), since they may easily feel overwhelmed by these multiple concerns.

If a victimized client reports a sense of being flooded or "feeling blank" while discussing their safety, therapists can start by empathically affirming this content-affective state with the client (e.g., "There's a lot going on inside right now, a lot of valid concerns for your safety, all tangled up") and propose helping by clearing a space (e.g., "Would it help if we took a moment to look inside and put all of these concerns on the table?"). Listing the concerns at this point should be grounded in the experience of the client. Therapists may facilitate this process by asking "What else keeps you from feeling safe, right now?" and then helping clients to symbolically set aside each troubling worry, such as by arranging them on a table or other containment metaphor, until a working distance is created. Therapists can then help to prioritize which concern to address first (e.g., "Out of these concerns, which feels more urgent for you to deal with?").

Once a safety concern is identified as a priority, engaging in action planning requires the maintenance of a sensitive balance between experiential responses of empathy, process guiding, and experiential presence, and non-experiential responses (e.g. providing information, advice on solving problems) (Elliott et al. 2004; Goldman & Greenberg 2015). For example, therapists can help clients by tentatively discussing their perceived risk of revictimization or lethality, identifying resources that are readily available in the client's milieu and in need of being accessed, asking if providing information about legal options and local and/or national resources would be helpful, and offering to help in planning contingency strategies if needed (Campbell 2001; Campbell & Glass 2013; McLaughlin 2017). Depending on the specific concern, this process can include discussing safety boundaries (e.g., defining and endorsing the limits of acceptable and unacceptable behavior) and/or other safety measures (e.g., exit plans, seeking informal or formal support), as well as consolidating practical life changes (e.g., ensuring the safety of children or helping with job search efforts) (Reisenhofer & Taft 2013; Zamora et al. 2012).

It is important to note, however, that even while engaging in more typified responses in this tailored version of the *clearing a space* task, therapists are encouraged to act with humanistic sensitivity. A resolution of this content-affective state should result in a deeper sense of having a stronger coping strategy for dealing with future problems from an optimal working distance, and a clarified action plan for implementing the necessary pragmatic solutions given the idiosyncratic experiences and context of the client.

Imaginal Confrontation for Long-Term Interpersonal Injuries

For victimized clients who have experienced cumulative violence in their relationships, a traumatic fear of others can become generalized overtime, contributing to difficulties in committing to, and maintaining, close relationships and leading to social isolation and withdrawal (Lindgren & Renck 2008; Orzeck et al. 2010). Experiencing shame, loneliness, and fear of a wide range of negative repercussions were also found to be obstacles to accessing social support (Evans & Feder 2016; Feder et al. 2006). For this reason, clients at the *maintenance* stage or even *termination* stage (Zamora et al. 2012), where they no longer struggle to maintain the necessary resources, may benefit from more direct work on long-term interpersonal injuries at the root of maladaptive shame by engaging in *empty-chair* work (see chapter 12, Elliott et al. 2004). The process of working with interpersonal injuries involves expressing feelings of resentment while imagining the other person in another chair (or conveying these feelings to the therapist) and then accessing more primary adaptive emotions (e.g., sadness, anger) to transform the underlying core vulnerability (Elliott et al. 2004; Goldman & Greenberg 2015).

Nevertheless, before proceeding with this highly evocative task, therapists and clients should ensure that the necessary contextual and internal resources are available, and that the client is prepared and informed about the nature of the intervention. In this regard, the therapeutic relationship serves a fundamental role throughout this process by facilitating the internalization of the accepting and soothing responses of the therapist to the most painful aspects of the client's experience (Greenberg 2014). This relational aspect

of therapy is paramount when working with victimized clients who could understandably fear being judged, trivialized or blamed for the abuse (Feder et al. 2006) and respond with intense affect dysregulation based on perceived invalidation cues (e.g., emotional flooding, dissociation) (Bogat et al. 2013).

Empty-chair work, which is also called "imaginal confrontation" when working with interpersonal trauma (Paivio & Pascual-Leone 2010), may begin by making contact with less evocative aspects that are associated with the abuse and then progress safely to the more evocative ones, such as confronting the imagined abusive other. Progressively, the therapist validates the emerging affective needs and helps the client to express them, which leads to a change in the representation of the abusive partner or significant other.

However, given the evocative nature of this process, victimized clients may naturally feel unprepared to express difficult, complex and painful emotions towards the imagined other, even after they are expressed to the therapist. In such cases, therapists can consider using the chair work by proxy strategy in which therapists voice these feelings for the client directly to the empty chair, helping clients to maintain a safe working distance (Pos & Paolone 2019). A complete resolution of the emotional injury can then take the form of reassigning blame and holding the other accountable (resolution through adaptive anger) and/or letting go of painful feelings toward that person (resolution through adaptive sadness) (Elliott et al. 2004; Paivio & Pascual-Leone 2010).

Beyond this point, victimized clients may feel an increased freedom to develop different aspirations and make innovative plans for the future, thus experiencing a new "expanded self" (Humbert et al. 2013). They may also become more motivated to establish new positive relationships with others (Zamora et al. 2012).

Conclusion

Recent research shows that clients who are victimized by their intimate partners may benefit from interventions that are increasingly tailored to their level of readiness for change and emotional processing difficulties. In this paper, we have discussed how emotion-focused principles and refined experiential tasks can be integrated into psychotherapy to address this need. Our aim here was to contribute to the development of more responsive treatments that intentionally utilize the adaptive potential of a client's strengths, goals, values, and current needs. Future studies could apply a process analysis methodology to further refine and manualize the proposed tailored tasks (e.g., Sutherland et al. 2014), and more research is needed to assess their feasibility and efficacy. Nonetheless, similar integrations of emotion-focused tasks have been successful at treating offenders of intimate partner violence (Pascual-Leone et al. 2011) and families struggling with eating disorders (Lafrance Robinson et al. 2016), suggesting that facilitating emotional change through process-experiential tasks benefits a wide range of client populations.

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References

Bauman, E. M., Haaga, D. A. F., & Dutton, M. A. (2008). Coping with intimate partner violence: Battered women's use and perceived helpfulness of emotion-focused coping strategies. *Journal of Aggression, Maltreatment & Trauma, 17*(1), 23–41. https://doi.org/10.1080/10926770802250942.

Bliss, M. J., Ogley-Oliver, E., Jackson, E., Harp, S., & Kaslow, N. J. (2008). African American women's readiness to change abusive relationships. *Journal of Family Violence, 23*(3), 161–171. https://doi.org/10.1007/s10896-007-9138-3.

Bogat, G. A., Garcia, A. M., & Levendosky, A. A. (2013). Assessment and psychotherapy with women experiencing intimate partner violence: Integrating research and practice. *Psychodynamic Psychiatry, 41*(2), 189–217. https://doi.org/10.1521/pdps.2013.41.2.189.

Buchbinder, E., & Karayanni, N. G. (2015). Rejection and choice: Arab battered women coping with stigmatization after leaving battered women's shelters in Israel. *Journal of Ethnic & Cultural Diversity in Social Work, 24*(3), 235–250. https://doi.org/10.1080/15313204.2014.991981.

Burke, J. G., Mahoney, P., Gielen, A., McDonnell, K., & a, & O'Campo, P., (2009). Defining appropriate stages of change for intimate partner violence survivors. *Violence and Victims, 24*(1), 36–51. https://doi.org/10.1891/0886-6708.24.1.36.

Campbell, J. (2001). Safety planning based on lethality assessment for partners of batterers in intervention programs. *Journal of Aggression, Maltreatment & Trauma, 5*(2), 129–143. https://doi.org/10.1300/J146v05n02_08.

Campbell, J., & Glass, N. (2013). Safety planning, danger, and lethality assessment. In C. E. Mitchell (Ed.), *Health care response to domestic violence*. Oxford: Oxford University Press.

Chang, J. C., Dado, D., Ashton, S., Hawker, L., Cluss, P. A., Buranosky, R., et al. (2006). Understanding behavior change for women experiencing intimate partner violence: Mapping the ups and downs using the stages of change. *Patient Education and Counseling, 62*(3), 330–339. https://doi.org/10.1016/j.pec.2006.06.009.

Chang, J. C., Dado, D., Hawker, L., Cluss, P. A., Buranosky, R., Slagel, L., et al. (2010). Understanding turning points in intimate partner violence: Factors and circumstances leading

women victims toward change. *Journal of Women's Health, 19*(2), 251–259. https://doi.org/10.1089/jwh.2009.1568.

Cluss, P. A., Chang, J. C., Hawker, L., Hudson Scholle, S., Dado, D., Buranosky, R., et al. (2006). The process of change for victims of intimate partner violence support for a psychosocial readiness model. *Women's Health Issues, 16*(5), 262–274. https://doi.org/10.1016/j.whi.2006.06.006.

Devries, K. M., Mak, J. Y. T., García-Moreno, C., Petzold, M., Child, J. C., Falder, G., et al. (2013). The global prevalence of intimate partner violence against women. *Science, 340*(6140), 1527–1528. https://doi.org/10.1126/science.1240937.

Eckstein, J. J. (2011). Reasons for staying in intimately violent relationships: Comparisons of men and women and messages communicated to self and others. *Journal of Family Violence, 26*, 21–30. https://doi.org/10.1007/s10896-010-9338-0.

Edhborg, M., Nasreen, H. E., & Kabir, Z. N. (2015). "I can't stop worrying about everything"-experiences of rural Bangladeshi women during the first postpartum months. *International Journal of Qualitative Studies on Health and Well-Being, 10*, 1–10. https://doi.org/10.3402/qhw.v10.26226.

Elliott, R., Watson, J. C., Goldman, R. N., & Greenberg, L. S. (2004). *Learning emotion-focused therapy: The process-experiential approach to change*. Washington, DC: American Psychological Association.

Estefan, L. F., Coulter, M. L., & VandeWeerd, C. (2016). Depression in women who have left violent relationships. *Violence Against Women, 22*(11), 1397–1413. https://doi.org/10.1177/1077801215624792.

Evans, M. A., & Feder, G. S. (2016). Help-seeking amongst women survivors of domestic violence: A qualitative study of pathways towards formal and informal support. *Health Expectations, 19*(1), 62–73. https://doi.org/10.1111/hex.12330.

Evans, M., Malpass, A., Agnew-Davies, R., & Feder, G. (2018). Women's experiences of a randomised controlled trial of a specialist psychological advocacy intervention following domestic violence: A nested qualitative study. *PLoS ONE, 13*(11), 1–11. https://doi.org/10.1371/journal.pone.0193077.

Feder, G. S., Hutson, M., Ramsay, J., & Taket, A. R. (2006). Women exposed to intimate partner violence: Expectations and experiences when they encounter health care professionals: A meta-analysis of qualitative studies. *Archives of Internal Medicine, 166*(1), 22–37. https://doi.org/10.1001/archinte.166.1.22.

Gleiser, K., Ford, J. D., & Fosha, D. (2008). Contrasting exposure and experiential therapies for complex posttraumatic stress disorder. *Psychotherapy, 45*(3), 340–360. https://doi.org/10.1037/a0013323.

Goldman, R. N., & Greenberg, L. S. (2015). *Case formulation in emotion-focused therapy: Co-creating clinical maps for change*. Washington, DC: American Psychological Association.

Goldman, R. N., Greenberg, L. S., & Angus, L. (2006). The effects of adding emotion-focused interventions to the client-centered relationship conditions in the treatment of depression. *Psychotherapy Research, 16*(5), 537–549. https://doi.org/10.1080/10503300600589456.

Greenberg, L. S. (2011). *Emotion-focused therapy*. Washington, DC: American Psychological Association.

Greenberg, L. S. (2014). The therapeutic relationship in emotion-focused therapy. *Psychotherapy, 51*(3), 350–357. https://doi.org/10.1037/a0037336.

Greenberg, L. S. (2015). *Emotion-focused therapy: Coaching clients to work through their feelings* (2nd ed.). Washington, DC: American Psychological Association.

Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress, 5*(3), 377–391. https://doi.org/10.1007/BF00977235.

Humbert, T. K., Bess, J. L., & Mowery, A. M. (2013). Exploring women's perspectives of overcoming intimate partner violence: A phenomenological study. *Occupational Therapy in Mental Health, 29*(3), 246–265. https://doi.org/10.1080/0164212X.2013.819465.

Ivany, A. S., Bullock, L., Schminkey, D., Wells, K., Sharps, P., & Kools, S. (2018). Living in fear and prioritizing safety: Exploring women's lives after traumatic brain injury from intimate partner violence. *Qualitative Health Research, 28*(11), 1708–1718. https://doi.org/10.1177/1049732318786705.

Johnson, D. M., Johnson, N. L., Perez, S. K., Palmieri, P. A., & Zlotnick, C. (2016). Comparison of adding treatment of PTSD during and after shelter stay to standard care in residents of battered women's shelters: Results of a randomized clinical trial. *Journal of Traumatic Stress, 29*(4), 365–373. https://doi.org/10.1002/jts.22117.

Joshi, R., Arora, M., & Mukherjee, R. (2020). Do women justify the violence they face? Intimate partner violence among married women. *Medical Journal of Dr. D.Y. Patil Vidyapeeth, 13*(2), 113–119. https://doi.org/10.4103/mjdrdypu.mjdrdypu_255_18.

Lafrance Robinson, A., Dolhanty, J., Stillar, A., Henderson, K., & Mayman, S. (2016). Emotion-focused family therapy for eating disorders across the lifespan: A pilot study of a 2-day transdiagnostic intervention for parents. *Clinical Psychology & Psychotherapy, 23*(1), 14–23. https://doi.org/10.1002/cpp.1933.

Lagdon, S., Armour, C., & Stringer, M. (2014). Adult experience of mental health outcomes as a result of intimate partner violence victimisation: A systematic review. *European Journal of Psychotraumatology*. https://doi.org/10.3402/ejpt.v5.24794.

Levitt, H. M., Whelton, W. J., & Iwakabe, S. (2019). Integrating feminist-multicultural perspectives into emotion-focused therapy. In Leslie S. Greenberg & R. N. Goldman (Eds.), *Clinical handbook of emotion-focused therapy* (pp. 425–444). Washington: American Psychological Association

Lim, B. H. P., Valdez, C. E., & Lilly, M. M. (2015). Making meaning out of interpersonal victimization. *Violence Against Women, 21*(9), 1065–1086. https://doi.org/10.1177/1077801215590670.

Lindgren, M. S., & Renck, B. (2008). "It is still so deep-seated, the fear": Psychological stress reactions as consequences of intimate partner violence. *Journal of Psychiatric and Mental Health Nursing, 15*(3), 219–228. https://doi.org/10.1111/j.1365-2850.2007.01215.x.

McCleary-Sills, J., Namy, S., Nyoni, J., Rweyemamu, D., Salvatory, A., & Steven, E. (2016). Stigma, shame and women's limited agency in help-seeking for intimate partner violence. *Global Public Health, 11*(1–2), 224–235. https://doi.org/10.1080/17441692.2015.1047391.

McLaughlin, K. D. (2017). Ethical considerations for clinicians treating victims and perpetrators of intimate partner violence. *Ethics & Behavior, 27*(1), 43–52. https://doi.org/10.1080/10508422.2016.1185012.

Norcross, J. C., Krebs, P. M., & Prochaska, J. O. (2011). Stages of change. *Journal of Clinical Psychology, 67*(2), 143–154. https://doi.org/10.1002/jclp.20758.

Orzeck, T. L., Rokach, A., & Chin, J. (2010). The effects of traumatic and abusive relationships. *Journal of Loss and Trauma, 15*(3), 167–192. https://doi.org/10.1080/15325020903375792.

Paivio, S. C., Jarry, J. L., Chagigiorgis, H., Hall, I., & Ralston, M. (2010). Efficacy of two versions of emotion-focused therapy for resolving child abuse trauma. *Psychotherapy Research, 20*(3), 353–366. https://doi.org/10.1080/10503300903505274.

Paivio, S. C., & Pascual-Leone, A. (2010). *Emotion-focused therapy for complex trauma: An integrative approach*. Washington, DC: American Psychological Association.

Pascual-Leone, A., Bierman, R., Arnold, R., & Stasiak, E. (2011). Emotion-focused therapy for incarcerated offenders of intimate partner violence: A 3-year outcome using a new whole-sample

matching method. *Psychotherapy Research, 21*(3), 331–347. https://doi.org/10.1080/10503307.2011.572092.

Pos, AE., & Paolone, DA. (2019). Emotion-focused therapy for personality disorders. In Leslie S. Greenberg & R. N. Goldman (Eds.), *Clinical handbook of emotion-focused therapy.* (pp. 381–402). Washington: American Psychological Association

Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy, 19*(3), 276–288.

Prochaska, J. O., & Norcross, J. C. (2014). *Systems of psychotherapy: A transtheoretical analysis* (8th ed.). Stamford, CT: Cengage Learning.

Reisenhofer, S., & Taft, A. (2013). Women's journey to safety-the transtheoretical model in clinical practice when working with women experiencing intimate partner violence: A scientific review and clinical guidance. *Patient Education and Counseling, 93*(3), 536–548. https://doi.org/10.1016/j.pec.2013.08.004.

Rizo, C. F., Givens, A., & Lombardi, B. (2017). A systematic review of coping among heterosexual female IPV survivors in the United States with a focus on the conceptualization and measurement of coping. *Aggression and Violent Behavior, 34*, 35–50. https://doi.org/10.1016/j.avb.2017.03.006.

Shurman, L. A., & Rodriguez, C. M. (2006). Cognitive-affective predictors of women's readiness to end domestic violence relationships. *Journal of Interpersonal Violence, 21*(11), 1417–1439. https://doi.org/10.1177/0886260506292993.

Sorrentino, A. E., Iverson, K. M., Tuepker, A., True, G., Cusack, M., Newell, S., et al. (2020). Mental health care in the context of intimate partner violence: Survivor perspectives. *Psychological Services*. https://doi.org/10.1037/ser0000427.

Stöckl, H., Devries, K., Rotstein, A., Abrahams, N., Campbell, J., Watts, C., et al. (2013). The global prevalence of intimate partner homicide: A systematic review. *The Lancet, 382*, 859–865. https://doi.org/10.1016/S0140-6736(13)61030-2.

Sutherland, O., Peräkylä, A., & Elliott, R. (2014). Conversation analysis of the two-chair self-soothing task in emotion-focused therapy. *Psychotherapy Research, 24*(6), 738–751. https://doi.org/10.1080/10503307.2014.885146.

Thomas, K. A., Goodman, L., & Putnins, S. (2015). "I have lost everything": Trade-offs of seeking safety from intimate partner violence. *American Journal of Orthopsychiatry, 85*(2), 170. https://doi.org/10.1037/ort0000044.

Timulak, L., & Keogh, D. (2020). Emotion-focused therapy: A transdiagnostic formulation. *Journal of Contemporary Psychotherapy, 50*, 1–13. https://doi.org/10.1007/s10879-019-09426-7.

Tiwari, A., Chan, K. L., Cheung, D. S. T., Fong, D. Y. T., Yan, E. C. W., & Tang, D. H. M. (2015). The differential effects of intimate terrorism and situational couple violence on mental health outcomes among abused Chinese women: a mixed-method study. *BMC Public Health, 15*, 314. https://doi.org/10.1186/s12889-015-1649-x.

Trabold, N., McMahon, J., Alsobrooks, S., Whitney, S., & Mittal, M. (2018). A systematic review of intimate partner violence interventions: State of the field and implications for practitioners. *Trauma, Violence, & Abuse, 21*(2), 311–325. https://doi.org/10.1177/1524838018767934.

Tran, H. N., Lipinski, A. J., Peter, S. C., Dodson, T. S., Majeed, R., Savage, U. C., et al. (2019). The association between posttraumatic negative self-conscious cognitions and emotions and maladaptive behaviors: Does time since trauma exposure matter? *Journal of Traumatic Stress, 32*(2), 249–259. https://doi.org/10.1002/jts.22388.

Warshaw, C., Sullivan, C. M., & Rivera, E. A. (2013). *A systematic review of trauma-focused interventions for domestic violence survivors*. Chicago: National Collaborating Center for Domestic Violence, Trauma and Mental Health.

World Health Organization. (2013). *Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence*. Geneva: World Health Organization.

Zamora, R., Muñoz-Cobos, F., Varo, M. L. B., Rodríguez, A. C., Carretero, M. L. M., Fraile, I. O., et al. (2012). Stages of change model: Adjustment to biographical narrations of women whose are victims of intimate partner violence. *Anales De Psicología / Annals of Psychology, 28*(3), 805–822. https://doi.org/10.6018/analesps.28.3.156081.

Zapor, H., Wolford-Clevenger, C., & Johnson, D. M. (2018). The association between social support and stages of change in survivors of intimate partner violence. *Journal of Interpersonal Violence, 33*(7), 1051–1070. https://doi.org/10.1177/0886260515614282.